		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042853

Facility Name: Highland Health Care Center

Address: 1450 26th Street (Number) Highland (City) 62249 (Zip Code)

County: Madison

Telephone Number: 618 654-2368 **Fax #** 618 654-4741

IDPA ID Number: 330748151003

Date of Initial License for Current Owners: 06/01/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code		X	Corporation		Other		
			"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Cathy Storr **Telephone Number:** (714) 596-7713

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cathy Storr, Principal
(Firm Name & Address) Kellogg & Andelson Accountancy Corporation, 16162 Beach Blvd. Suite 308 Huntington Beach, CA 92647
(Telephone) (714) 596-7713 Fax # (714) 596-7721

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,548	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,848	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,785	59	5,070	12,914	8
9	SNF/PED					9
10	ICF	14,455	9,143	24	23,622	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,240	9,202	5,094	36,536	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.99%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
n/a

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 2/1/64

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 4,791

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Highland Health Care Center # 0042853 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	179,101	24,469	13,083	216,653		216,653		216,653			1
2	Food Purchase		135,787		135,787		135,787		135,787			2
3	Housekeeping	89,896	12,192	18,412	120,500		120,500		120,500			3
4	Laundry	80,905	14,022	239	95,166		95,166		95,166			4
5	Heat and Other Utilities			88,117	88,117		88,117		88,117			5
6	Maintenance	52,271	6,780	16,024	75,075		75,075		75,075			6
7	Other (specify):*											7
8	**TOTAL General Services**	402,173	193,250	135,875	731,298		731,298		731,298			8
	B. Health Care and Programs											
9	Medical Director			12,180	12,180		12,180		12,180			9
10	Nursing and Medical Records	1,517,568	111,741	29,131	1,658,440		1,658,440	733	1,659,173			10
10a	Therapy	163	990	431,241	432,394		432,394	54,904	487,298			10a
11	Activities	62,168	4,056	3,787	70,011		70,011		70,011			11
12	Social Services	34,953	124	1,756	36,833		36,833		36,833			12
13	Nurse Aide Training											13
14	Program Transportation	11,198		778	11,976		11,976		11,976			14
15	Other (specify):*							20,988	20,988			15
16	**TOTAL Health Care and Programs**	1,626,050	116,911	478,873	2,221,834		2,221,834	76,625	2,298,459			16
	C. General Administration											
17	Administrative	95,006		277,800	372,806		372,806	(111,998)	260,808			17
18	Directors Fees											18
19	Professional Services			257	257		257		257			19
20	Dues, Fees, Subscriptions & Promotions			588	588		588	(588)				20
21	Clerical & General Office Expenses	164,412	8,730	158,460	331,602		331,602	(90,905)	240,697			21
22	Employee Benefits & Payroll Taxes			532,514	532,514		532,514		532,514			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,045	16,045		16,045		16,045			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			109,594	109,594		109,594		109,594			26
27	Other (specify):*											27
28	**TOTAL General Administration**	259,418	8,730	1,095,258	1,363,406		1,363,406	(203,491)	1,159,915			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,287,641	318,891	1,710,006	4,316,538		4,316,538	(126,866)	4,189,672			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Highland Health Care Center #0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			63,366	63,366		63,366	(199)	63,167			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,295	32,295		32,295		32,295			32
33	Real Estate Taxes			39,650	39,650		39,650		39,650			33
34	Rent-Facility & Grounds			497,394	497,394		497,394		497,394			34
35	Rent-Equipment & Vehicles			1,311	1,311		1,311		1,311			35
36	Other (specify):*							29,152	29,152			36
37	**TOTAL Ownership**			634,016	634,016		634,016	28,953	662,969			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		181,691	14,690	196,381		196,381	92	196,473			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,272	70,272		70,272		70,272			42
43	Other (specify):*		27,600		27,600		27,600		27,600			43
44	**TOTAL Special Cost Centers**		209,291	84,962	294,253		294,253	92	294,345			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,287,641	528,182	2,428,984	5,244,807		5,244,807	(97,821)	5,146,986			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(135)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,023)	21		13
14	Non-Care Related Interest	(29,402)	21		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(65)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,954)	21		24
25	Fund Raising, Advertising and Promotional	(9,036)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(24,640)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (104,255)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	6,434		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 6,434		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (97,821)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Highland Health Care Center

ID# 0042853

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Dues and Subscriptions	$ (588)	20	1
2	Bank Charges	(444)	21	2
3	Public Relations	(5,876)	21	3
4	Patient Theft and Loss	(32)	21	4
5	Prior Year Expense	(1,749)	21	5
6	Barber Revenue	(1,177)	21	6
7	Personal Items	(1,404)	21	7
8	Other Revenue	(345)	21	8
9	Prior Year Revenue	(263)	21	9
10	Depreciation Reconciliation	(199)	30	10
11	Bonus Overaccrual	(12,563)	17	11
12	Director of Nursing Bonus	(733)	17	12
13	Director of Nursing Bonus	733	10	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,640)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Highland Health Care Center # 0042853 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	733	0	0	0	0	0	0	0	0	0	0	733	10
10a	Therapy	0	0	54,904	0	0	0	0	0	0	0	0	54,904	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	20,988	0	0	0	0	0	0	0	0	0	20,988	15
16	**TOTAL Health Care and Programs**	733	20,988	54,904	0	0	0	0	0	0	0	0	76,625	16
	C. General Administration													
17	Administrative	(13,296)	(98,702)	0	0	0	0	0	0	0	0	0	(111,998)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(588)	0	0	0	0	0	0	0	0	0	0	(588)	20
21	Clerical & General Office Expenses	(90,905)	0	0	0	0	0	0	0	0	0	0	(90,905)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(104,789)	(98,702)	0	0	0	0	0	0	0	0	0	(203,491)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(104,056)	(77,714)	54,904	0	0	0	0	0	0	0	0	(126,866)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Highland Health Care Center** **#** **0042853** **Report Period Beginning:** **01/01/04** **Ending:** **12/31/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(199)	0	0	0	0	0	0	0	0	0	0	(199)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	29,152	0	0	0	0	0	0	0	0	0	29,152	36
37	**TOTAL Ownership**	(199)	29,152	0	0	0	0	0	0	0	0	0	28,953	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	92	0	0	0	0	0	0	0	92	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	92	0	0	0	0	0	0	0	92	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(104,255)	(48,562)	54,904	92	0	0	0	0	0	0	0	(97,821)	45

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Care Inc.	100%	see attached		see attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	15	HO Alloc Direct Care	$	Covenant Care Inc.	100.00%	$ 20,988	$ 20,988	1
2	V	17	HO Alloc Indirect Care	277,800	Covenant Care Inc.	100.00%	179,098	(98,702)	2
3	V	36	HO Alloc Capital Amount		Covenant Care Inc.	100.00%	29,152	29,152	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 277,800			$ 229,238	$ * (48,562)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Physical Therapy	$ 219,964	Select Therapy		$ 250,709	$ 30,745	15
16	V	10a	Occupational Therapy	126,571	Select Therapy		144,263	17,692	16
17	V	10a	Speech Therapy	46,269	Select Therapy		52,736	6,467	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 392,804			$ 447,708	$ * 54,904	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Supplies	$	Pharmacy Support Services, Inc.		$	$	15
16	V	39	Medical Supplies	629	Pharmacy Support Services, Inc.		721	92	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 629			$ 721	$ * 92	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	n/a								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Covenant Care Inc.
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (949) 349-1200
Fax Number: (949) 349-1900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	15	HO Alloc. -Direct Care	accumulated cost			$	$		$ 20,988	1
2	17	HO Alloc. -Indirect Care	accumulated cost						179,098	2
3	36	HO Alloc. - Capital Amount	accumulated cost						29,152	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 229,238	25

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Select Therapy
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (949) 349-1200
Fax Number: (949) 349-1900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10a	Physical Therapy				$	$		$ 250,709	1
2	10a	Occupational Therapy							144,263	2
3	10a	Speech Therapy							52,736	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 447,708	25

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Pharmacy Support Services, Inc.
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (949) 349-1200
Fax Number: (949) 349-1900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies				$	$		$	1
2	39	Medical Supplies							721	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 721	25

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Banque Paribas		X	Purchase of facility		02/03/98	$ 752,000	$ (658,000)		various	$ 32,295	1
2	Less: non-care interest										(29,402)	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 752,000	$ (658,000)			$ 2,893	9
	B. Non-Facility Related*											
10												10
11	Interest Income										(135)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (135)	14
15	TOTALS (line 9+line14)						$ 752,000	$ (658,000)			$ 2,758	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ n/a Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Highland Health Care Center # 0042853 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	39,650	2
3. Under or (over) accrual (line 2 minus line 1).	$	39,650	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	39,650	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	44,504	8
2000	49,800	9
2001	48,931	10
2002	51,094	11
2003	54,381	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Highland Health Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0042853

CONTACT PERSON REGARDING THIS REPORT Cathy Storr

TELEPHONE (714) 596-7713 FAX #: (714) 596-7721

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-2-24-08-08-201-004	Long Term Care	$	$ 54,380.83
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$ 54,380.83

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,432 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	various			1994	5,613		5	1,298	1,298	5,613	9
10	various			1995	6,998		5	999	999	6,998	10
11	various			1996	4,048		5	864	864	4,048	11
12	various			1997	8,482		5	2,318	2,318	8,482	12
13	various			1998	22,969		5			22,969	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Related Party Allocations								68
69	Financial Statement Depreciation			36,863			(36,863)		69
70	TOTAL (lines 4 thru 69)		$ 48,110	$ 36,863		$ 5,479	$ (31,384)	$ 48,110	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 48,110	$ 36,863		$ 5,479	$ (31,384)	$ 48,110	1
2	Wallpaper	1999	2,310		5	39	39	2,310	2
3	Temperature Control unit anit-scald valve (2 each)	1999	636		5	11	11	636	3
4	Oxygen Shed installation hardware	1999	83		5	1	1	83	4
5	Water Heater- 91 gallon	1999	3,345		5	167	167	3,345	5
6	Hot Water Heater	1999	2,359		5	118	118	2,359	6
7	Draperies, cubical curtains, bedspreads	1999	14,407		5	1,201	1,201	14,407	7
8	TV Wall Mount 221 x131	1999	65		5	6	6	65	8
9	Renovation Design & Construction - Patio	1999	28,138		5	2,814	2,814	28,138	9
10	Installed Pyro Chem Fire Suppression System	1999	1,591		5	186	186	1,591	10
11	Renovation Design & Construction - Patio	1999	29,635		5	3,458	3,458	29,635	11
12	Concrete and supplies	1999	309		5	36	36	309	12
13	Repairs to roof and interior damage	1999	2,620		5	349	349	2,620	13
14	Hanging cubicle curtains	1999	149		5	22	22	149	14
15	Cubical curtains & bedspreads	1999	6,314		5	947	947	6,314	15
16	Renovation of Activities Room (slats & vein savers)	1999	435		5	73	73	435	16
17	Fire Alarm 50%	1999	18,589		5	3,408	3,408	18,589	17
18	Circulating Pump	1999	2,050		5	410	410	2,050	18
19	Fire Alarm System	2000	17,441		5	3,488	3,488	17,151	19
20	Repairs to roof- reclassed from CIP	2000	95,515		5	19,103	19,103	92,331	20
21	Kemper claim check no. 019-0-808-173	2000	(92,940)		5	(18,588)	(18,588)	(89,842)	21
22	Install Fire Alarm system	2000	1,056		5	211	211	1,003	22
23	Renovation Design & Construction of Alzheimer's Unit	2000	1,765		5	353	353	1,677	23
24	Balance on fire alarm system from 1/00	2000	4,003		5	801	801	3,736	24
25	Paint exterior of bulding	2000	497		5	99	99	464	25
26	roof drains	2000	1,680		5	336	336	1,568	26
27	compressor in "B" hall air conditioner	2000	823		5	165	165	741	27
28	10 GE Air Conditioners	2000	5,272		5	1,054	1,054	4,745	28
29	shelves & coutertops (front office & nurse's stations)	2001	3,732		5	829	829	2,971	29
30	shelves & coutertops (front office & nurse's stations)	2001	158		5	35	35	126	30
31	shelves & coutertops (front office & nurse's stations)	2001	100		5	22	22	80	31
32	front main door	2001	627		5	139	139	499	32
33	carpet for front office & nurse's station	2001	445		5	101	101	353	33
34	TOTAL (lines 1 thru 33)		$ 201,319	$ 36,863		$ 26,873	$ (9,990)	$ 198,748	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 201,319	$ 36,863		$ 26,873	$ (9,990)	$ 198,748	1
2	Carpet for front office & nurses station	2001	328		5	74	74	260	2
3	Wall cap counter	2001	610		5	141	141	469	3
4	Door alarm system	2001	3,220		5	758	758	2,462	4
5	Water Heater (serve E,F,A,B Halls)	2001	3,014		5	738	738	2,276	5
6	New door locking device	2001	948		5	232	232	716	6
7	Bathtub	2001	7,908		5	1,977	1,977	5,931	7
8	Plumbing accessories	2002	772		5	206	206	566	8
9	Plumbing accessories	2002	1,033		5	276	276	758	9
10	Wallpaper for Therapy Room	2002	405		5	111	111	295	10
11	30" Tub	2002	147		5	43	43	104	11
12	3 ton A/C	2002	1,799		5	527	527	1,272	12
13	Nurses Station Countertops	2002	1,060		5	318	318	742	13
14	Seal Coat Lot	2002	978		5	309	309	669	14
15									15
16	Fire Board Replacement	2003	1,678		5	813	813	1,214	16
17	Therapy Room Remodeling	2003	2,896		5	1,241	1,241	1,655	17
18	Reno Walk-In Cooler	2003	106		5	454	454	605	18
19	Remodel OP Therapy	2003	2,824		5	1,210	1,210	1,614	19
20	Heating/Air Conditioning Unit	2003	751		5	150	150	150	20
21	Replace Sprinkler Heads	2004	1,610		5	268	268	268	21
22	New Carpet	2004	708		5	106	106	106	22
23	Repairs on Compressor	2004	1,126		5	38	38	38	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 235,240	$ 36,863		$ 36,863	$	$ 220,918	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 168,229	$ 25,468	$ 25,468	$	10	$ 113,396	71
72	Current Year Purchases	13,060	836	836		10	836	72
73	Fully Depreciated Assets	98,980				10	98,980	73
74								74
75	TOTALS	$ 280,269	$ 26,304	$ 26,304	$		$ 213,212	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transportation	1994 Ford Wagon	1994	$ 26,845	$	$	$	5	$ 26,845	76
77										77
78										78
79										79
80	TOTALS			$ 26,845	$	$	$		$ 26,845	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 542,354	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 63,167	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 63,167	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 460,975	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in progress '02	$ 10,137	92
93	Construction in progress '03	(9,457)	93
94	Construction in progress '04	17,718	94
95		$ 18,398	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Highland Leasehold, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				475,430			4
5								5
6								6
7	TOTAL				$ 475,430 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 4/1/97
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$ 502,318
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 1,311 Description: see supplemental schedule 14.1
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 126,571	$		$ 126,571	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			242,367			242,367	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				196,381		196,381	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 368,938	$ 196,381		$ 565,319	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Highland Health Care Center # 0042853 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,600	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	127,642		3
4	Supply Inventory (priced at)	56,331		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,813		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached schedule 17.1	1,506,353		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,696,739	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	236,195		15
16	Equipment, at Historical Cost	307,113		16
17	Accumulated Depreciation (book methods)	(461,405)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	313,316		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(56,658)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attached schedule 17.1	68,832		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 407,393	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,104,132	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 23,682	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,650		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached schedule 17.1	1,536,938		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,669,270	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached schedule 17.1	658,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 658,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,327,270	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (223,138)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,104,132	$	48

***(See instructions.)**

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (661,722)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (661,722)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(544,817)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **Contributed capital from Covenant Care Cali**	983,401	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 438,584	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (223,138)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,878,384	1
2	Discounts and Allowances for all Levels	(1,980,720)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,897,664	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	909,493	6
7	Oxygen	5,440	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 914,933	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,177	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	450,268	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	61,942	19
20	Radiology and X-Ray	25,164	20
21	Other Medical Services	346,695	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 885,246	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	135	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 135	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule 19.1	2,012	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,012	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,699,990	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	731,298	31
32	Health Care	2,221,834	32
33	General Administration	1,361,486	33
	B. Capital Expense		
34	Ownership	634,017	34
	C. Ancillary Expense		
35	Special Cost Centers	223,981	35
36	Provider Participation Fee	72,191	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,244,807	40
41	**Income before Income Taxes (line 30 minus line 40)****	(544,817)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (544,817)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,885	1,901	$ 62,853	$ 33.06	1
2	Assistant Director of Nursing	1,716	1,716	38,211	22.27	2
3	Registered Nurses	17,008	17,408	371,670	21.35	3
4	Licensed Practical Nurses	13,102	13,410	235,579	17.57	4
5	Nurse Aides & Orderlies	64,002	65,508	786,060	12.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10	10	163	16.30	8
9	Activity Director	1,405	1,405	17,172	12.22	9
10	Activity Assistants	3,629	3,746	44,995	12.01	10
11	Social Service Workers	1,981	1,989	34,953	17.57	11
12	Dietician					12
13	Food Service Supervisor	1,829	1,829	24,363	13.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,374	18,578	154,738	8.33	15
16	Dishwashers					16
17	Maintenance Workers	3,398	3,438	52,271	15.20	17
18	Housekeepers	9,747	9,882	89,896	9.10	18
19	Laundry	8,285	8,364	80,905	9.67	19
20	Administrator	2,260	2,260	95,006	42.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,153	8,284	144,707	17.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,578	1,586	19,915	12.56	31
32	Other Health Care(specify)	1,916	1,927	22,985	11.93	32
33	Other(specify)	1,120	1,120	11,199	10.00	33
34	TOTAL (lines 1 - 33)	161,398	164,361	$ 2,287,641 *	$ 13.92	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192+mileage	$ 7,145	1-3	35
36	Medical Director	monthly	12,180	9-3	36
37	Medical Records Consultant	30	1,180	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,840	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28+mileage	1,514	11-3	44
45	Social Service Consultant	33+mileage	1,756	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	30	$ 27,615		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	61	2,219	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	61	$ 2,219		53

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jessica Fritz (1/1/04-3/04)	Administrator		$ 17,153
Robert McDonald (3/30/04-12/31/04)	Administrator		77,853
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,006

B. Administrative - Other

Description	Amount
Management Fees- Covenant Care Inc.	$ 277,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 277,800

C. Professional Services

Vendor/Payee	Type	Amount
	Legal	$ 257
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 257

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,383
Unemployment Compensation Insurance	24,015
FICA Taxes	170,755
Employee Health Insurance	246,404
Employee Meals	482
Illinois Municipal Retirement Fund (IMRF)*	
401K/Other	13,475
TOTAL (agree to Schedule V, line 22, col.8)	$ 532,514

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues and Subscriptions	588
Less: Dues and Subscriptions	(588)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,493
In-State Travel	11,697
Seminar Expense	855
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,045

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Highland Health Care Center **#** 0042853 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **858** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **70,272**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **482** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Ernst & Young** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not specific to facility**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.